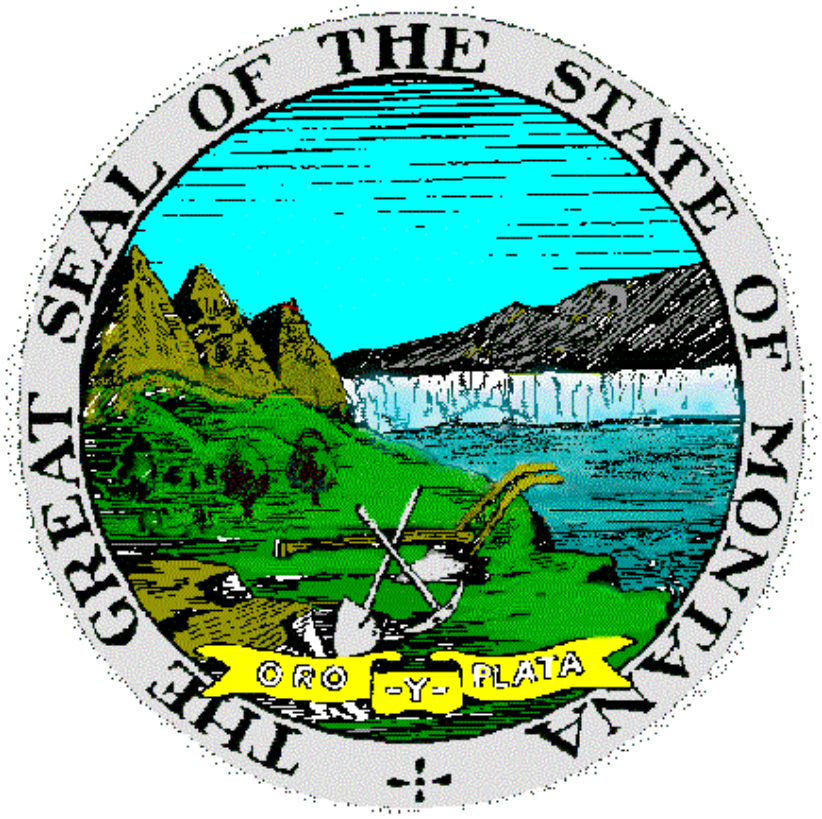
MONTANA DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

Section 1115 Waiver for Health Care Reform

DY9 February 2012 – January 2013 Annual Report



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Executive Summary
The Basic Medicaid Program has remained a positive source of Medicaid coverage since the program's inception in 1996. The Basic Program is comprised of mandatory Medicaid benefits and a collection of optional services available for emergencies and when necessary, for seeking and maintaining employment. These services are available to able-bodied adults (neither pregnant nor disabled) who are parents and/or caretaker relatives of dependent children. Currently, there are no changes or major issues with the Basic Program.

Basic Medicaid Demonstration Information
The Montana Medicaid Program is authorized under 53-6-101, Montana Codes Annotated, and Article XII, Section 3 of the Montana Constitution. The Department of Public Health and Human Services (DPHHS) administers the Medicaid Program. The Basic Medicaid Program are the medical services provided for able-bodied adults (neither pregnant nor disabled) and who are parents and/or caretaker relatives of dependent children, eligible for Medicaid under Sections 1925 or 1931 of the Social Security Act. The Basic Program is operated under a Section 1115 waiver, offers all mandatory services and a reduced package of Medicaid optional services through a fee-for-service delivery. Amount, duration, and scope of services, under Section 1902(a)(10)(B) of the Act are waived enabling Montana to carry out the 1115 demonstration.

In February 1996, Montana implemented its state-specific welfare reform program known as Families Achieving Independence in Montana (FAIM). This sweeping change involved the cash assistance, food stamp, and Medicaid programs that were administered on the federal side by several agencies under multiple statutes. As part of welfare reform, Montana obtained a Section 1115 waiver, approved in February 1996. On October 23, 2003, the Department submitted an 1115 waiver application to CMS requesting approval to continue the Basic Medicaid Program. CMS approved the waiver application on January 29, 2004, for a five-year period from February 1, 2004 through January 31, 2009. Terms of the request and the approval were consolidated into an Operational Protocol document as of February 2005. The waiver structure has remained constant throughout the life of the Basic Program. The State must submit a quarterly Basic Medicaid report as one of the Operational Protocol conditions.

A HIFA proposal was submitted on June 27, 2006. 1115 Basic Medicaid Waiver amendments were submitted on March 23, 2007, and January 28, 2008, requesting seven new optional and expansion populations. Tribal Consultation was completed on December 14, 2007. As a result of discussions with CMS, Montana submitted a revised 1115 Basic Medicaid Waiver amendment on June 6, 2008, requesting four new populations. July 30, 2009, and August 6, 2010, submittals requested only one population, MHSP Waiver individuals (individuals with schizophrenia and individuals with bipolar), in addition to Able Bodied Adults. CMS approved the waiver extension and the request to insure the additional population, effective December 1, 2010.

Department of Public Health and Human Services
Richard Opper is the Department Director and Mary E. Dalton is the State Medicaid Director. The Montana Medicaid Program consists of the following Divisions: Health Resources Division, Disability Services Division, Addictive and Mental Disorders Division, Child and Family Services Division, Senior and Long Term Care Division, Quality Assurance Division, Human and Community Services Division, and the Public Health and Safety Division. Medicaid eligibility is determined in the Human and Community Services Division.

Medicaid Program Goal
To assure that medically necessary medical care is available to all eligible Montanans within available funding resources.

Basic Excluded Services
The Basic package is the Full Medicaid benefit, with the following medical services generally excluded under Basic Medicaid: audiology, dental and denturist, durable medical equipment, eyeglasses, optometry and ophthalmology for routine eye exams, personal care services, home infusion and hearing aids. Under the FAIM waiver, these services were excluded to align with the basic medical coverage of a work-related insurance program. That is, an employed individual who is insured under a work-related insurance policy would not have coverage for the list of excluded services.

Basic Medicaid Policies
All requirements of the Medicaid Program expressed in law not expressly waived or identified as not applicable in the award letter of which the terms and conditions are part, shall apply to Montana's demonstration. Montana Medicaid Program administrative rules, policies, processes, eligibility, cost sharing, and reimbursement apply to individuals on Basic Medicaid unless specified, like the Basic plan of benefits.

Emergencies and Essentials for Employment Program
DPHHS recognizes there may be situations where the excluded services are necessary as in an emergency or when essential for employment. Coverage for the excluded services may be provided at the State's discretion in cases of emergency or when essential to obtain or maintain employment. Examples of emergency circumstances include, but are not limited to, coverage for emergency dental situations, medical conditions of the eye, which include but are not limited to annual dilated eye exams for individuals with diabetes or other medical conditions, and certain medical supplies such as diabetic supplies, prosthetic devices and oxygen. In these situations, the State will provide approval to the provider, and make associated records available upon CMS request. Medicaid manuals contain Basic information and are found on the Department site at http://medicaidprovider.mt.gov/providertype.

The *General Information for Providers, Medicaid and Other Medical Assistance Programs*, can be found at http://medicaidprovider.mt.gov/.

Medicaid provider training is offered several times a year and Basic Medicaid billing, policies, and procedures are included. Providers, when inquiring about member eligibility, receive eligibility information including whether a member is receiving Full or Basic Medicaid regardless of the various eligibility methods of Faxback, Voice Response, or when contacting the Office of Public Assistance, the Department, or Montana Medicaid's Provider Relations.

Medicaid members are given a copy of the Montana Medicaid Member Guide, found at: http://dphhs.mt.gov/MontanaHealthcarePrograms/Welcome/MemberServices. A chart of Medicaid covered benefits is published with additional service details. Members receive education and information regarding Full and Basic Medicaid services through the Montana Medicaid Hotline. The provider community and members who are affected by the 1115 waiver are accustomed to the provisions of the waiver.

Basic Medicaid Population

Basic Medicaid members include Able Bodied Adults who are not pregnant, not blind, under age 65, and not disabled or receiving SSI. These members are eligible for Basic Medicaid under the designation of Family Medicaid and Transitional Medicaid.

Basic Medicaid Population February 2012 – January 2013 DY9 Average					
	1st Quarter February – April 2012	2nd Quarter May – July 2012	3rd Quarter August – October 2012	4th Quarter November – December 2012 - January 2013	February 2012 – January 2013 DY9 Average
Family Medicaid	72%	72%	72%	72%	72%
Transitional Medicaid	20%	19%	19%	19%	19%
WMHSP Schizophrenia	4%	4%	4%	4%	4%
WMHSP Bipolar	5%	5%	5%	5%	5%

*Note: CMS notified Montana that the Breast and Cervical populations are not one of the approved populations covered in Section 1925 or Section 1931. Montana took action to correct this oversight and instituted Full Medicaid benefits on 9/1/07, for this population.
*MHSP Waiver populations were effective 12/1/10.

Basic and Full Medicaid Enrollment DY9 Average

In DY9 a quarterly average of 8,793 individuals were enrolled in Basic Medicaid compared to the 28,457 Full Medicaid individuals, age 21-64.

Basic and Full Medicaid Enrollment February 2012 – January 2013 DY9 Average					
	1st Quarter February – April 2012	2nd Quarter May – July 2012	3rd Quarter August – October 2012	4th Quarter November – December 2012 - January 2013	February 2012 – January 2013 DY9 Average
Basic Medicaid Enrollment	8,805	8,770	8,791	8,806	8,793
Full Medicaid Enrollment (Age 21-64)	27,922	27,749	28,822	29,336	28,457

Full (Age 21-64) and Basic Medicaid Gender, Ethnic and Race DY9 Average

Basic Medicaid is 68% predominately female as compared to 64% females for all Medicaid in the 21-64 age group. There are 4% more males in Full Medicaid than the Basic population. The American Indian quarterly average for Basic is 28%, which is 9% more than the Full Medicaid average of 19%.

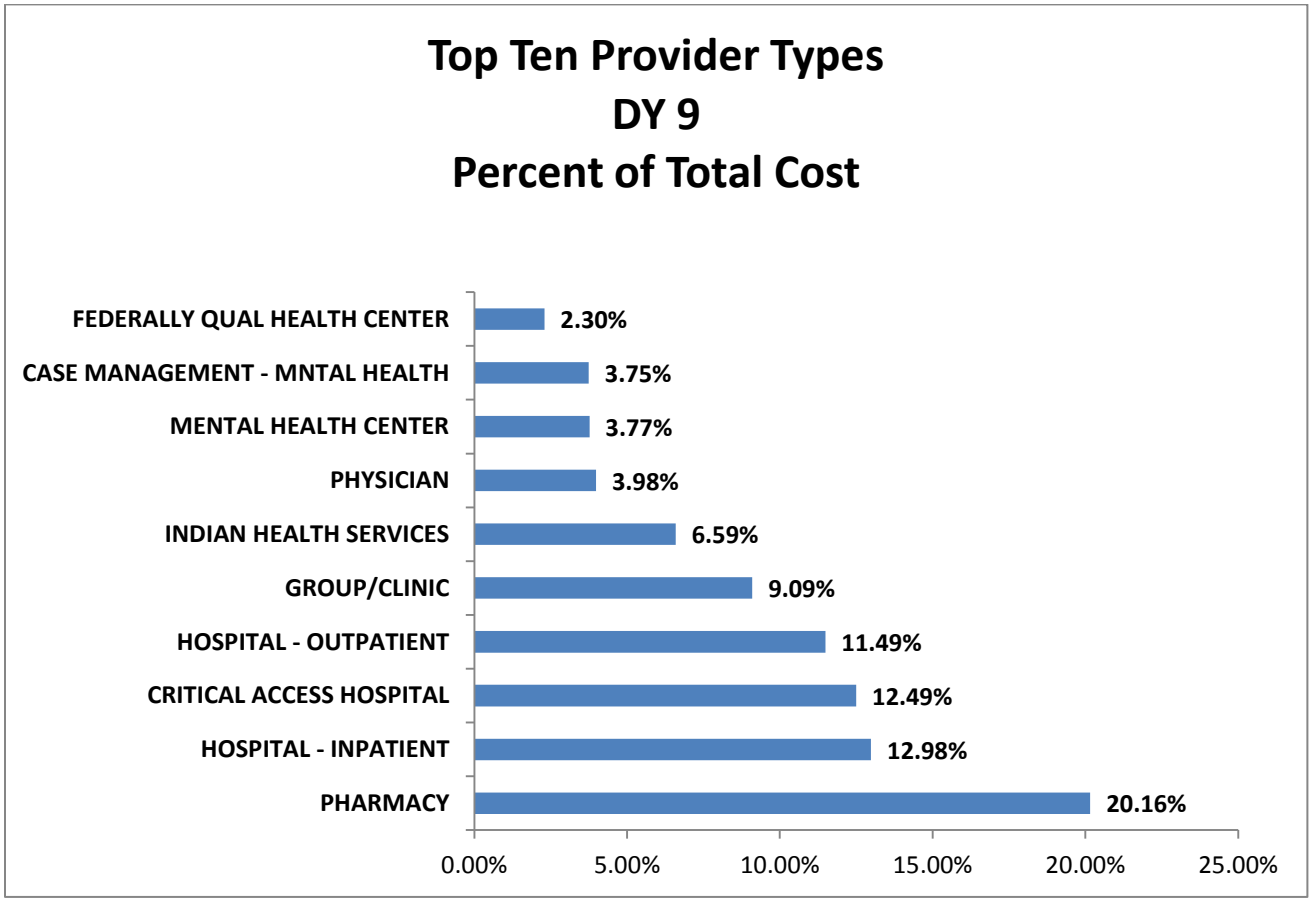
Basic Medicaid Gender, Ethnic and Race February 2012 – January 2013 DY9 Average					
	1st Quarter February – April 2012	2nd Quarter May – July 2012	3rd Quarter August – October 2012	4th Quarter November – December 2012 - January 2013	February 2012 – January 2013 DY9 Average
Gender					
Female	68%	68%	68%	68%	68%
Male	32%	32%	32%	32%	32%
Ethnic and Race (Plus Any Other)					
Hispanic of Any Race	3%	3%	3%	3%	3%
White	70%	70%	69%	71%	70%
American Indian/AK	29%	28%	27%	28%	28%
Other: African American, Asian, Pacific Islander	1%	1%	1%	1%	1%

Full Medicaid Gender, Ethnic and Race (Age 21-64) February 2012 – January 2013 DY9 Average					
	1st Quarter February – April 2012	2nd Quarter May – July 2012	3rd Quarter August – October 2012	4th Quarter November – December 2012 - January 2013	February 2012 – January 2013 DY9 Annual
Gender					
Female	63%	63%	64%	64%	64%
Male	37%	37%	36%	36%	36%
Ethnic and Race (Plus Any Other)					
Hispanic of Any Race	3%	3%	3%	3%	3%
White	78%	78%	78%	80%	79%
American Indian/AK	19%	19%	18%	18%	19%
Other: African American, Asian, Pacific Islander	1%	1%	1%	1%	1%

**Ethnic and race data are not unique counts. Data is from MMIS as of January 2013.*

DY 9 Expenditures by Provider Type

PROVIDER PAY TO TYPE	2/1/2012 to 4/30/2012	5/1/2012 to 7/31/2012	8/1/2012 to 10/31/2012	11/1/2012 to 1/31/2013	Total	Percent of Total
PHARMACY	$ 2,286,429.29	$ 2,313,797.31	$ 2,247,068.03	$ 2,222,698.57	$ 5,841,158.99	20.16%
HOSPITAL - INPATIENT	$ 1,204,130.75	$ 1,501,177.09	$ 1,455,990.54	$ 1,679,860.61	$ 5,621,171.06	12.98%
CRITICAL ACCESS HOSPITAL	$ 1,422,789.82	$ 1,482,150.62	$ 1,450,570.52	$ 1,265,660.10	$ 5,169,369.19	12.49%
HOSPITAL - OUTPATIENT	$ 1,239,892.28	$ 1,332,505.49	$ 1,371,947.07	$ 1,225,024.35	$ 4,091,259.65	11.49%
GROUP/CLINIC	$ 1,091,683.46	$ 1,053,548.67	$ 1,024,089.88	$ 921,937.64	$ 2,964,500.79	9.09%
INDIAN HEALTH SERVICES	$ 256,692.00	$ 1,294,988.34	$ 778,371.28	$ 634,449.17	$ 1,791,241.92	6.59%
PHYSICIAN	$ 523,223.37	$ 451,653.14	$ 431,524.22	$ 384,841.19	$ 1,696,368.95	3.98%
MENTAL HEALTH CENTER	$ 432,634.62	$ 412,820.35	$ 398,797.64	$ 452,116.34	$ 1,685,658.67	3.77%
CASE MANAGEMENT - MENTAL HEALTH	$ 351,258.93	$ 425,145.80	$ 443,975.40	$ 465,278.54	$ 1,032,827.95	3.75%
FEDERALLY QUALIFED HEALTH CENTER	$ 300,694.03	$ 262,331.02	$ 239,961.19	$ 229,841.71	$ 820,360.38	2.30%
Grand Total					**$ 44,989,974.27**	



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